105TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPORT
105–374

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

NOVEMBER 4, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BURTON of Indiana, from the Committee on Government Reform and Oversight, submitted the following

R E P O R T

[To accompany H.R. 1836]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Reform and Oversight, to whom was referred the bill (H.R. 1836) to amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

59–006

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Health Care Protection Act of 1997".

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) AMENDMENTS.—Section 8902a of title 5, United States Code, is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(iii) by adding at the end the following:

"(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;"; and

(B) in paragraph (2)(A), by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)";

(2) in subsection (b)—

(A) by striking "The Office of Personnel Management may bar" and inserting "The Office of Personnel Management shall bar"; and

(B) by amending paragraph (5) to read as follows:

"(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).";

(3) by redesignating subsections (c) through (d) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

"(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

"(1) Any provider—

"(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

"(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

"(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

"(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

"(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

"(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.";

(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows:

"(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

"(A) an item or service not provided as claimed,

"(B) charges in violation of applicable charge limitations under section 8904(b), or

"(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);";

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after "under this section" the first place it appears the following: "(where such debarment is not mandatory)";

(6) in subsection (g) (as so redesignated by paragraph (3))—

(A) by striking "(g)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

"(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).";

(B) in paragraph (3)—

(i) by inserting "of debarment" after "notice"; and

(ii) by adding at the end the following: "In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).";

(C) in paragraph (4)(B)(i)(I) by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)"; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking "(h)(1)" and all that follows through the end of paragraph (2) and inserting the following:

"(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

"(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion."; and

(8) in subsection (i) (as so redesignated by paragraph (3))—

(A) by striking "subsection (c)" and inserting "subsection (d)"; and

(B) by adding at the end the following: "The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS.—(A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER.—Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking "organization;" and inserting "organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;".

(b) SERVICE BENEFIT PLAN.—Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking "plan," and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States,".

(c) PREEMPTION.—Section 8902(m) of title 5, United States Code, is amended by striking "(m)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.".

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN.—For purposes of chapter 89 of title 5, United States Code, any period of enrollment—

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE.—(1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual—

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, annuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been

allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if—

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN.—Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND.—The Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(e) ADMINISTRATION AND REGULATIONS.—The Office of Personnel Management—

(1) shall administer the provisions of this section to provide for—

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

"§ 8903b. Authority to readmit an employee organization plan

"(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

"(b) A contract for a plan approved under this section shall require the carrier—

"(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

"(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.".

(2) CONFORMING AMENDMENT.—The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

"8903b. Authority to readmit an employee organization plan.".

(3) APPLICABILITY.—

(A) IN GENERAL.—The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE.—For purposes of applying section 8903b(a) of title 5, United States Code (as amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting "second contract year" for "third contract year".

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN.—

(1) IN GENERAL.—Subsection (e) of section 8909 of title 5, United States Code, is amended by striking "(e)" and inserting "(e)(1)" and by adding at the end the following:

"(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

"(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.".

(2) TRANSITION RULE.—In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accordance with section 8909(e) of title 5, United States Code, as amended by this subsection, by—

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL.—Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking "$20,000" and inserting "$30,000".

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS.—

(1) IN GENERAL.—Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION.—A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of such title (as amended by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

"(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.".

I. SUMMARY OF LEGISLATION

H.R. 1836, as amended by the Committee, amends several provisions in title 5, United States Code. It provides the Office of Personnel Management (OPM) additional tools to fight waste, fraud, and abuse in the Federal Employees Health Benefits (FEHB) program. With these tools, OPM will be able to deal swiftly with health care providers who try to defraud the FEHB program. OPM will be better equipped to bar health care providers who engage in misconduct from participating in the FEHB program or to impose monetary penalties on them. The bill also provides that an association of organizations may underwrite health care plans in the FEHB program, and it broadens the current statutory language preempting State insurance laws.

In addition, the bill permits certain employees of the Federal Deposit Insurance Corporation (FDIC) and the Federal Reserve Board (Fed) to participate in the FEHB program, and it requires OPM to encourage carriers who contract with third parties to obtain discounts from health care providers to seek assurances that the conditions for the discounts are fully disclosed to such providers. It also establishes statutory requirements for readmitting health care plans sponsored by employee organizations that have previously discontinued participation in the FEHB program. Under current law, when a health care plan discontinues participation in the FEHB program, OPM must credit that plan's remaining contingency reserves to those plans that remained in the FEHB program in the contract year after the discontinuance. This bill requires OPM to complete the distribution by the end of the second contract year after the plan is discontinued.

The maximum amount of the physicians comparability allowance under 5 U.S.C. § 5948 is increased from $20,000 to $30,000.

The bill also amends 5 U.S.C. § 8902(k) to explicitly permit carriers to provide for direct access and direct payments to licensed health care providers who are not currently enumerated in the statute.

II. Background and Need for the Legislation

Section 1

H.R. 1836 was introduced by Mr. Burton of Indiana to strengthen the integrity and standards of the FEHB program and allow it to maintain its reputation as a high quality and cost-effective program. The FEHB program is the largest employer-sponsored health insurance system in the country. In 1997, the $16 billion FEHB program will insure more than nine million Federal employees, retirees, and their dependents. Partial portability, the absence of preexisting condition limitations, and an annual open enrollment period are facets of the FEHB program that make it an extremely attractive health care system. The program's market orientation has effectively contained costs through private sector competition with limited governmental intervention. The program is often cited as a model of efficiency and effectiveness that the private sector and the public sector should attempt to replicate. This bill will improve the program and its performance without changing the market principles that are the key to its success.

Section 2

Section 2 of this bill addresses the debarment of health care providers engaging in fraudulent practices. This provision would strengthen the ability of OPM to bar health care providers who engage in professional and or financial misconduct from participating in the FEHB program or to impose monetary penalties on them. Under this bill, the administrative sanctions authority would conform more closely with provisions of Medicare law. The parallels between these provisions and Medicare law should benefit not only OPM, but also carriers and health care providers, who are already familiar with interpretations and practices under similar Medicare provisions.

In addition, this bill streamlines the debarment process by generally permitting OPM to debar a provider before a hearing is held. However, upon request, the provider would be entitled to an administrative hearing after an adverse determination is made if the provider shows that due process rights were not previously afforded with respect to any finding of fact which is relied upon as a cause for the adverse determination. The hearing will be held before a hearing officer who shall be designated by the Director of OPM and conducted without regard to the requirements of subchapter II of chapter 5 and chapter 7 of title 5, United States Code. Judicial review shall lie with the United States District Court for the District of Columbia or other appropriate district, rather than, as under current law, with the United States Court of Appeals for the Federal Circuit.

Under current law, OPM is permitted to debar health care providers on certain grounds, but it is not required to do so. This bill makes debarment mandatory if a health care provider is convicted of certain criminal offenses or is currently debarred, suspended or otherwise excluded from any procurement or nonprocurement activity within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994.

OPM retains its existing authority to debar health care providers on grounds relating to professional licensing, and this bill adds four additional grounds for permissive debarment, including the determination that a provider has charged substantially more than the provider's customary charge for health care services or supplies without good cause, or has charged for substandard or medically unnecessary health care services or supplies. The determination that a service or supply is medically unnecessary must be made by trained reviewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. These trained reviewers may be employees of OPM, other appropriately trained Federal employees, or contractors.

Existing law does not mandate a minimum period of debarment. This bill, however, requires that providers convicted under Federal or State law of certain offense must be debarred for at least 3 years.

Under current law, OPM, in consultation with the Attorney General, may impose a civil monetary penalty of up to $10,000 on a health care provider guilty of certain misconduct. This bill modifies the grounds upon which OPM may assess such penalties. OPM's authority to impose a monetary penalty on health care providers for excessive charges or charges for substandard or medically unnecessary services or supplies is deleted. (That misconduct becomes, instead, grounds for permissive debarment.) But it is given additional authority to impose a civil penalty for charges exceeding Medicare limitations in violation of 5 U.S.C. § 8904(b) or charging for items or services provided during a period of debarment.

These modifications of OPM's authority to debar health care providers and impose monetary penalties upon them will strengthen OPM's ability to protect the FEHB program—and the employees and retirees who depend upon it—from fraudulent or abusive practices that drive up health care costs and premiums.

SECTION 3

The bill amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. The revised definition makes clear that an association of organizations, or other entities, may be the carrier for any health benefits plan in the FEHB program. The new description makes clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. Indeed, although the government-wide Service Benefit Plan historically has been underwritten by all of the affiliates of the sponsoring association, the withdrawal of an affiliate in a State would not affect the sponsoring association's ability to continue offering the plan in that State.

In addition, this bill broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live. This change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts. It will also prevent carriers' cost-cutting initiatives from being frustrated by State laws. For example, a carrier's effort to establish a preferred provider organization (PPO) across the country would not be jeopardized by State-mandated "any willing provider" statutes.

SECTION 4

Another important component of this bill provides consistent health benefit coverage for individuals who were covered by health care plans offered by the Board of Governors of the Federal Reserve System (Fed) or the Federal Deposit Insurance Corporation (FDIC). A number of years ago, the Fed decided to drop out of the FEHB program and sponsor a separate health care plan for its employees. But in 1993, the Fed elected to abandon this health care experiment and offer its employees only FEHB program coverage. The Fed permitted some retirees and employees to participate in a health care plan offered by one of the Federal Reserve Banks because current law generally requires five years of continuous enrollment in the FEHB program before individuals may participate in it after retirement,. Consequently, some current employees approaching retirement age and a number of individuals who retired while the Fed had its own system are not eligible to participate in the FEHB program during retirement. The FDIC faces a similar situation because it plans to eliminate its alternative health insurance plan at the end of 1997. Without this legislation, the FDIC and the Fed will have to establish a non-FEHB program plan for those employees who are ineligible for coverage. This would be administratively burdensome and costly to these Federal agencies and, ultimately, to the taxpayers. Under this proposal, these ineligible employees would be offered FEHB program coverage at no additional cost to the Government.

SECTION 5

The Committee has received complaints from numerous providers doing business with health plans in the Federal Employees Health Benefits (FEHB) program about dubious, and possibly unethical, practices in which discounts are taken without contractual rights or on a basis other than negotiated or agreed to by contract. The genesis of these complaints to the Committee coincide with the insertion of language in the Office of Personnel Management's (OPM) annual FEHB call letter which appears to have had the effect of increasing these dubious practices in the FEHB program.

Organizations that take advantage of health care providers by arranging for a carrier to obtain access to discounted rates they are not entitled to are the focus of Section 5 of H.R. 1836. The first victims of this practice are the doctors and hospitals. But in the end, all of us pay the price as the losses incurred by these providers are shifted to other consumers of medical services. Eventually this cost shifting will lead to higher prices for medical services, higher insurance premiums, or a decline in the quality of services available.

The Committee's sole interest is in ensuring that the integrity of the FEHB program is maintained and that the imprimatur of the United States Government is not used in any way to encourage or condone an unethical health care practice within the FEHB program. The Committee strongly believes that the full disclosure of discounted rate agreements is necessary to protect not just health care providers, but more importantly, the very integrity of the FEHB program. The Committee does not intend to interject the Government into the contracting arrangements between private sector health care providers, vendors and health plans; nor is it the role of the Government to ensure that either party negotiates a contract to its advantage. The Committee, however, does expect OPM to be aware of dubious practices in the health care industry and to be cognizant of the influence of its directives to FEHB plans on those practices.

The language included in Section 5 of the bill as introduced, was modified during the mark up of the bill held on October 22, 1997 by the Subcommittee on Civil Service. As a result of further bipartisan discussion with the Office of Personnel Management, alternative language was drafted by OPM and was inserted into Section 5 during the full Committee Business Meeting held on October 31, 1997. The language provided to the Committee by OPM was adopted verbatim.

As a result of this action by the Congress, OPM is expected to clarify the instructions in its annual call letter to ensure that FEHB carriers understand that in obtaining provider discounts, the standard to be observed is not only one of cost-effectiveness, but ethical practices as well. Further, the Committee expects the Office of Personnel Management to respond appropriately to specific and credible complaints concerning discounts taken without disclosure of the conditions for such discounts. Finally, the Committee expects the Office of Personnel Management to be mindful of its own Federal Employees Health Benefits Acquisition Regulation (FEHBAR) promulgated at 48 Code of Federal Regulations 1609.7001 (b)(2) requiring legal and ethical business and health care practices in the performance of FEHB contracts.

SECTION 6

This bill also establishes rules under which a health care plan sponsored by an employee organization may reenter the FEHB program after previously discontinuing its participation. Under current law, such plans may not reenter. The bill will permit such a plan to again participate in the FEHB program after the end of the third contract year following its discontinuance (2 contract years in the case of plans applying for a contract year beginning before January 1, 2000). This waiting period is necessary to discourage plans from leaving the FEHB program in order to eliminate their high risk policyholders and then quickly begin again with a clean slate. Such plans must also be underwritten by a subcontractor licensed to issue group health insurance in all the States and the District of Columbia and demonstrate experience in service delivery within a managed care system.

In addition, this bill requires OPM to distribute the contingency reserves of certain discontinued plans within 2 contract years. Under current law, OPM is required to distribute those reserves to plans continuing in the FEHB program in the contract year after the discontinuance. OPM has interpreted the current statutory language to provide it with unlimited time in which to complete this distribution. The Committee believes, however, that OPM should be required to completely distribute these reserves in 2 years in order to offset the additional liabilities assumed by continuing plans.

SECTION 7

The bill also increases the maximum physicians comparability allowance Federal agencies may pay from $20,000 to $30,000 per year. In 1978, Congress enacted the Physicians Comparability Act of 1978 (PCA), which provides for such annual allowances, in response to a critical shortage of Federal physicians and income disparities between physicians employed by the Departments of Defense and Veterans Affairs and other Federal doctors. That Act has been reauthorized several times, most recently in H.R. 2541, the Fiscal Year 1998 Treasury, Postal, and General Government Services Appropriations Act. But the maximum allowance has not been increased since 1987, and the gap between special pay provisions for VA physicians and Federal doctors covered by the PCA has widened in the last four years. Federal physicians also earn considerably less than private sector doctors. But Federal physicians conduct research on AIDS, cancer, and heart disease; they protect the safety of food and drugs; and they perform many other valuable functions. The Committee believes the maximum allowance should be increased to ensure the Federal Government can recruit and retain highly-trained and well-qualified physicians to perform these important functions.

SECTION 8

Under current law, carriers offering health benefit plans under the FEHB program are required to provide for direct access and direct payments to certain enumerated health care providers. In recent years, some providers have argued that providers who are not specifically enumerated are placed at a competitive disadvantage in gaining access to the FEHB program market place. Nothing in the statute currently prevents carriers from voluntarily providing direct access or payments to other health care providers. Nevertheless, the Committee has been advised that on occasion this provision has been misconstrued to prohibit such arrangements. The bill will prevent such misreading of the statute in the future by explicitly permitting FEHB program carriers to provide direct access and direct payment to licensed health care providers who are not specifically identified in the statute.

III. Legislative Hearings and Committee Actions

H.R. 1836 was introduced on June 10, 1997 by the Honorable Dan Burton. The bill was referred to the Committee on Government Reform and Oversight on June 10, 1997, and it was referred to the Subcommittee on Civil Service on June 11, 1997. The subcommittee held a mark up on October 22, 1997. Representative Mica offered an amendment in the nature of a substitute. Representative Sessions offered an amendment to the amendment in the nature of a substitute, and Representative Morella offered two. The amendment offered by Representative Sessions and one of the amendments offered by Representative Morella, as well as the amendment in the nature of a substitute were adopted by voice votes. (The other amendment offered by Representative Morella was withdrawn.) The subcommittee favorably reported the bill, as amended, to the full Committee by a voice vote.

On October 31, 1997, the Committee on Government Reform and Oversight met to consider the bill as amended by the subcommittee. Chairman Burton offered an amendment in the nature of a substitute. The amendment in the nature of a substitute was adopted by voice vote. The Committee favorably reported the bill, as amended, to the full House by voice vote.

IV. Committee Hearings and Written Testimony

The Committee held no hearings and received no written testimony. However, the Subcommittee on Civil Service did examine the debarment provisions of H.R. 1836 and the issue of “silent PPOs” at an oversight hearing, “FEHB Rate Hikes—What’s Behind Them?,” on October 8, 1997. William E. Flynn, III, OPM’s Associate Director, Retirement and Insurance Service, testified that OPM supported the improved debarment procedures contained in this bill. Stephen W. Gammarino, Vice President, Federal Employee Programs, Blue Cross-Blue Shield Association, testified that the Blue Cross-Blue Shield Association does not support or use “silent PPOs” and does not believe their use should be required or mandated. He cautioned, however, against overregulation of rate agreements between carriers, networks, and health care providers as a method of controlling costs. The private sector, he testified, is much more innovative than government and can move much more quickly to control costs without government intervention.

V. Explanation of the Bill as Reported: Section-by-Section Analysis

Sec. 1. The short title of the bill is the Federal Employees Health Care Protection Act of 1997.

Sec. 2. This section amends 5 U.S.C. § 8902a regarding the Office of Personnel Management's (OPM) authority to debar or otherwise sanction health care providers in the Federal Employees Health Benefits Program (FEHBP).

Subsection (a)(1) adds a new paragraph to define the term "should know". Under this definition, the term means that a person acted in deliberate ignorance or with reckless disregard of the truth or falsity of information, and no proof of specific intent to defraud is required. This is the same definition given the term under Medicare law in 42 U.S.C. § 1320a–7a(7).

Subsections (a)(2)–(3) provide OPM with both permissive and mandatory authority to debar health care providers. Under current law, OPM has only permissive authority to debar such providers for certain reasons.

Subsection (a)(2) requires OPM to debar health care providers under the following circumstances:

1. Conviction, under Federal or State law, relating to fraud, corruption, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care service or supply;
2. Conviction, under Federal or State law, relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;
3. Conviction, under Federal or State law, in connection with the interference with or obstruction of a Federal or State investigation or prosecution of a criminal offense described in (1) or (2) above;
4. Conviction, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and
5. Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or non-procurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1944).

Subsection (a)(3) permits OPM to debar:

1. Any provider whose license has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity, or who surrendered his license while a formal disciplinary proceeding relating to one of these subjects was pending;
2. Any provider that is an entity owned, directly or indirectly, by an individual who is convicted of any offense that is a ground for mandatory debarment, against whom a civil monetary penalty has been assessed, or who has been debarred from participating in FEHB program, or in which such an individual holds a control interest of 5% or more;

3. Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action on which the sanction was based;

4. Any provider that OPM determines has charged substantially more than the provider's customary charge for health care services or supplies (unless OPM finds there is good cause for such charge), or has charged for substandard or medically unnecessary health care services or supplies; or

5. Any provider that OPM determines has committed acts for which a civil penalty may be imposed.

A determination under clause (4) above that a service or supply is medically unnecessary must be made by trained reviewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. This requirement recognizes that the determination of whether services or supplies are not medically necessary is a medical judgment. Accordingly, that judgment must be made by individuals trained in reviewing such medical questions and on the basis of protocols developed by physicians, not by bureaucrats. This requirement will not impose an undue burden on OPM. OPM may use appropriately trained employees of its own to review these matters, or they may take advantage of the broad expertise of the many trained medical personnel, including doctors, in the Federal workforce. OPM may also choose to contract with private organizations to perform some or all of these tasks.

Subsection (a)(4) modifies OPM's authority to impose a monetary civil penalty. Under current law, OPM can impose a penalty for several reasons, including OPM's determination that in connection with "a claim", a health care provider has (1) charged for services or supplies that the provider knows or should have known were not provided as claimed, or (2) charged substantially more than his customary charges or for substandard or medically unnecessary services or supplies. This subsection removes OPM's authority to impose a penalty based upon overcharges or substandard or medically unnecessary services or supplies. Instead, OPM is authorized to impose penalties based upon charges the provider knows or should have known exceeds Medicare limitations, as made applicable by 5 U.S.C. 8904(b), or were for an item or service furnished during a period when the provider was debarred from participation in FEHB program, other than services permitted under subsection (g)(2)(B) (as redesignated by this bill). In addition, the word "claims" is substituted for the words "a claim."

Subsection (a)(5) revises current law to provide that OPM is not required to consider certain statutory criteria relating to the appropriateness of debarment when debarment is mandatory.

Subsection (a)(6) amends current law with respect to the effective date of debarment, the period of debarment, and the termination of debarment. With one exception, this subsection provides that mandatory or permissive debarment is effective at such time and upon reasonable notice to the provider, carriers, and covered individuals, as OPM shall specify in regulations. A debarred provider may request a hearing after debarment. Unless OPM determines that the health or safety of patients warrants an earlier effective date, OPM cannot make a determination adverse to a provider under its permissive debarment authority for acts for which a civil penalty may be imposed or under its authority to impose a civil penalty for acts for which such a penalty may be imposed until the provider has been given reasonable notice and an opportunity for the determination to be made after a hearing to be held before adverse action is taken. This subsection also establishes a minimum debarment period of 3 years for certain criminal convictions. Finally, this subsection also amends current law to permit OPM to terminate mandatory debarment after the minimum debarment period if it determines that there is no basis under mandatory debarment authority for continuing debarment.

Subsection (a)(7) amends provisions relating to the notice and hearing requirements and to judicial review. Under current law, OPM may not debar a provider or impose a monetary penalty until after the provider has been given written notice and an opportunity for a hearing on the record, and any person affected by OPM's final adverse decision may obtain review in the United States Court of Appeals for the Federal Circuit. This subsection provides that a provider subject to an adverse determination by OPM is entitled to reasonable notice and an opportunity to request a hearing of record. OPM is required to grant a request for a hearing upon a showing that due process rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination. The hearing is not subject to subchapter II of chapter 5 or chapter 7 of title 5, which relate to administrative procedures and judicial review. Judicial review is available in the United States District Court for the District of Columbia, or for the district in which the plaintiff resides or has his or her principal place of business. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record, taken as a whole, to support the findings by OPM or unless OPM has abused its discretion.

Subsection (a)(8) amends current law regarding the collection of civil monetary penalties or assessments. Under this subsection, the amount of a penalty or assessment may be withheld from any sum then or later owed to the provider by the United States.

Subsection (b) establishes effective dates for the amendments made by this section. With three exceptions, these amendments take effect upon enactment. However, paragraphs (2), (3), and (5) of section 8902a(c), as amended by subsection (a)(3) of this Act, apply only to misconduct occurring after the date of enactment. Similarly, 5 U.S.C. 8902a(d)(1)(B), as amended by section (a)(4) of this Act, applies only with respect to charges for items or services furnished after the date of enactment, and section 8902a(g)(3), as amended by subsection (a)(6)(B) of this Act, shall apply only to debarments based upon convictions occurring after the date of the enactment of this Act.

SEC. 3. Subsection (a) of this section amends 5 U.S.C. 8901(7) to make clear that an association of organizations, or other entities, may sponsor a health benefits plan, including the government-wide Service Benefit Plan and that the sponsor is the carrier. The Service Benefit Plan has been historically, and is currently, sponsored by an association whose members are lawfully engaged in providing, paying for, or reimbursing the cost of group health plan functions. This revision conforms the statutory language to more clearly reflect this historical preference.

Subsection (b) amends section 8903 to make clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. The carrier for this plan allocates its rights and obligations under the FEHB program contract among its affiliates which elect to participate. This revision makes clear that the withdrawal of an affiliate in a state would not affect the ability of the sponsoring association to continue offering the plan in that State.

Subsection (c) amends section 8902(m) to broaden the preemption of State and local laws with respect to health care contracts under the FEHB program. This amendment confirms the intent of Congress (1) that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) completely displace State or local law relating to health insurance or plans and (2) that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, including managed care programs.

SEC. 4. This section permits certain individuals who have participated in health care plans established by the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System to participate in the FEHB program.

SEC. 5. This section requires OPM to encourage carriers who contract with third parties for discounted rates from health care providers to seek assurances that the conditions for those discounts have been fully disclosed to the health care providers.

SEC. 6. This section establishes rules under which employee-sponsored health plans that have discontinued participation in the FEHB program may be readmitted, and it compels OPM to distribute the contingency reserves of certain discontinued plans within 2 contract years. Under this subsection, a previously discontinued employee-sponsored plan may be allowed to participate in the FEHB program after the end of the third contract year following its discontinuance (2 contract years in the case of plans applying for a contract year beginning before January 1, 2000). Such plans must be underwritten by a subcontractor licensed to issue group health insurance in all the States and the District of Columbia and demonstrate experience in service delivery within a managed care system.

SEC. 7. This section increases the maximum physicians comparability payment under 5 U.S.C. § 5948 from $20,000 to $30,000.

SEC. 8. This section amends 5 U.S.C. § 8902(k) to make clear that carriers may voluntarily agree to provide direct access and direct payments to licensed health care providers even though such arrangements are not required by law.

VI. COMPLIANCE WITH RULE XI

Pursuant to rule XI, clause 2(l)(3)(A), of the Rules of the House of Representatives, under the authority of rule X, clause 2(b)(1) and clause 3(f), the results and findings for those oversight activities are incorporated in the recommendations found in the bill and in this report.

VII. Budget Analysis and Projections

H.R. 1836, as amended, provides for no new authorization, budget authority, or tax expenditures. Consequently, the provisions of section 308(a) of the Congressional Budget Act are not applicable.

VIII. Cost Estimate of the Congressional Budget Office

U.S. Congress,
Congressional Budget Office,
Washington, DC, November 3, 1997.

Hon. Dan Burton,
Chairman, Committee on Government Reform and Oversight,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1836, the Federal Employees Health Care Protection Act of 1997, as ordered reported by the House Committee on Government Reform and Oversight on October 31, 1997.

If you wish further details on these estimates, we will be pleased to provide them.

Sincerely,

June E. O'Neill, *Director.*

Enclosure.

H.R. 1836—Federal Employees Health Care Protection Act of 1997

Summary: H.R. 1836 would modify the administration of Federal Employees Health Benefits (FEHB) and raise the pay of certain physicians employed by the federal government. CBO estimates that enacting this bill would increase federal outlays by $2 million in 1998 and by between $30 million and $35 million over the 1998–2002 period, assuming appropriation of the authorized amounts. Because the bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply.

Section 2 would strengthen the Office of Personnel Management's (OPM's) ability to bar or sanction unethical health providers. Section 3 makes technical changes regarding national plans, and it would expand a preemption of state and local authority to regulate health care plans that provide coverage under FEHB. This preemption would represent a mandate under the Unfunded Mandates Reform Act of 1995, but CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Section 4 would allow retired employees of the Federal Deposit Insurance Corporation and the Federal Reserve Board access to FEHB plans. Section 5 would require OPM to encourage carriers who contract with third parties to obtain discounted rates from health care providers to seek assurances that the conditions for those discounts have been fully disclosed to the health care providers.

Section 6 clarifes FEHB procedures for the closure and readmittance of plans. Section 8 states that plans are allowed to provide direct access and payments to licensed health care providers, even when such arrangements are not required by law.

Section 7 would permit agencies to increase the maximum annual allowance payable to certain federal physicians from $20,000 to $30,000. CBO estimates that federal salary costs would increase by between $30 million and $35 million over the fiscal year 1998–2002 period, subject to the availability of funds.

Estimated cost to the Federal Government: CBO estimates that enactment of H.R. 1836 would not affect federal outlays for FEHB, but would increase federal salary costs, subject to the availability of funds. For purposes of the estimate, CBO assumes that the bill will be enacted by the middle of fiscal year 1998 and that agencies would modify service agreements with physicians by year's end. The estimated costs of this legislation would affect several budget functions.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002
SPENDING SUBJECT TO APPROPRIATION					
Spending on physicians comparability allowance under current law:					
Budget authority	27	27	27	27	14
Estimated outlays	27	27	27	27	14
Proposed changes:					
Estimated authorization level	2	9	9	9	5
Estimated outlays	2	9	9	9	5
Spending on physicians comparability allowance under H.R. 1836:					
Estimated authorization level	29	36	36	36	36
Estimated outlays	29	36	36	36	19

Basis of estimate

Spending for Federal employees health benefits

CBO estimates that H.R. 1836 would not significantly affect FEHB spending. The debarment and sanction provisions in Section 2 and the clarification of federal preemption of state insurance laws in Section 3 could possibly reduce FEHB costs.

Section 5 could discourage some FEHB plans from using certain discount vendors, potentially increasing costs. Based on a survey conducted by the Office of Personnel Management, however, FEHB plans believe that their discount vendors provide disclosure of the conditions of the discounts to health providers.

Section 4 would allow OPM to determine payments from the Federal Deposit Insurance Corporation and the Federal Reserve Board to the FEHB fund such that giving enrollees in plans sponsored by those agencies access to FEHB plans would not affect federal spending.

Section 8 allows plans to make direct payments to certain nonphysician providers. Because plans already have such authority, the enactment of that section would not change spending.

Physicians comparability allowance

Current law authorizes certain agencies to pay allowances of up to $20,000 a year to recruit and retain physicians for certain positions, such as those with long vacancies or high turnover rates. To receive the allowance, physicians must agree to work at least one year at the agency. CBO estimates that increasing the maximum annual allowance from $20,000 to $30,000 would increase salary costs by between $30 million and $35 million over the 1998–2002 period. This estimate is based on information provided by OPM, including data on the number of federal physicians receiving comparability allowances and the average annual premium that they receive under current service agreements. CBO estimates that the provision would increase the average allowance for 1,800 physicians by about $5,000 a year.

The authority for agencies to offer allowances to physicians was recently extended through fiscal year 2000 by the Treasury and General Government appropriations bill for fiscal year 1998 (P.L. 105–61). Under that authority, agencies and physicians can enter into contracts that extend through the end of fiscal year 2002. Most service agreements are made for two years. CBO assumes that the number of outstanding contracts in fiscal year 2001 will approximate the number of contracts in 2000, and the number of contracts in fiscal year 2002 will be about one-half of the number estimated for 2001. Thus, the increase in costs for fiscal year 2002 is lower than for previous years.

Pay-as-you-go considerations: None.

Intergovernmental and private sector mandates: H.R. 1836 would expand the preemption of state and local authority to regulate health care plans that provide coverage under FEHB. Current law prohibits state and local governments from regulating the nature and extent of coverage and benefits for people covered by FEHB if the regulation or law is inconsistent with the contract provisions. The new language would preclude state and local governments from regulating the provision of coverage or benefits as well, and it removes the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority. These changes would affect states that have comparably higher requirements for types of medical coverage offered by health plans. Although this preemption would be considered a mandate under UMRA, CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Estimate prepared by: Federal Cost Estimate: Jeff Lemieux, FEHB; John R. Righter, federal pay. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on Private Sector: Sandra Christensen.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

IX. Specific Constitutional Authority for this Legislation

Pursuant to rule XI, clause 2(l)(4), the Committee finds that clauses 14 and 18 of Article 1, Section 8 of the U.S. Constitution grants Congress the power to enact this law.

X. Committee Recommendation

On October 31, 1997, a quorum being present, the Committee ordered the bill, as amended, favorably reported to the House for consideration.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT—105TH CONGRESS ROLLCALL

Date: October 31, 1997.
Amendment No. 1.
Description: Amendment in the nature of a substitute.
Offered by: Mr. Dan Burton (IN).
Adopted by voice vote.
Final passage of H.R. 1836, as amended.
Offered by: Hon. Dan Burton (IN).
Adopted by voice vote.

XI. CONGRESSIONAL ACCOUNTABILITY ACT; PUBLIC LAW 104–1; SECTION 102(B)(3)

The amendments made by H.R. 1836 will apply to employees and former employees of the legislative branch who participate in the Federal Employees Health Benefits Program to the same extent as it applies to other participating employees.

XII. UNFUNDED MANDATES REFORM ACT; PUBLIC LAW 104–4; SECTION 423.

H.R. 1836, as amended, does not impose any Federal mandates on State, local, and tribal governments, or the private sector. Section 3(c) of the bill preempts any State and local law, and any regulations issued thereunder, that relates to health insurance or plans. The effect of these provisions is to permit health care plans participating in the FEHB program to offer uniform benefits nationwide because all questions relating to the nature, provision, or extent of coverage or benefits are to be determined by the terms of the contract between the carrier and OPM.

XIII. FEDERAL ADVISORY COMMITTEE ACT (5 U.S.C. APP.) SECTION 5(b)

The Committee finds that the legislation does not establish or authorize establishment of an advisory committee within the definition of 5 U.S.C. App., Section 5(b).

XIV. CHANGES IN EXISTING LAW

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 59—ALLOWANCES

* * * * * * *

SUBCHAPTER IV—MISCELLANEOUS ALLOWANCES

* * * * * * *

§ 5948. Physicians comparability allowances

(a) Notwithstanding any other provision of law, and in order to recruit and retain highly qualified Government physicians, the head of an agency, subject to the provisions of this section, section 5307, and such regulations as the President or his designee may prescribe, may enter into a service agreement with a Government physician which provides for such physician to complete a specified period of service in such agency in return for an allowance for the duration of such agreement in an amount to be determined by the agency head and specified in the agreement, but not to exceed—

(1) * * *

(2) ⟦$20,000⟧ *$30,000* per annum if the Government physician has served as a Government physician for more than twenty-four months.

For the purpose of determining length of service as a Government physician, service as a physician under section 4104 or 4114 of title 38 or active service as a medical officer in the commissioned corps of the Public Health Service under Title II of the Public Health Service Act (42 U.S.C. ch. 6A) shall be deemed service as a Government physician.

* * * * * * *

CHAPTER 89—HEALTH INSURANCE

Sec.
8901. Definitions.

* * * * * * *

8903b. Authority to readmit an employee organization plan.

* * * * * * *

§ 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) * * *

* * * * * * *

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee ⟦organization;⟧ *organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;*

* * * * * * *

§ 8902. Contracting authority

(a) * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

⟦(2)⟧ *(3)* The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

* * * * * * *

⟦(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.⟧

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * *

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term "provider of health care services or supplies" or "provider" means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term "individual covered under this chapter" or "covered individual" means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by section 8903 or 8903a; ⟦and⟧

(C) an individual or entity shall be considered to have been "convicted" of a criminal offense if—

(i) * * *

* * * * * * *

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which a judgment of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity[.]*; and*

(D) the term "should know" means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under [subsection (b) or (c)] *subsection (b), (c), or (d)*, a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

* * * * * * *

(b) [The Office of Personnel Management may bar] *The Office of Personnel Management shall bar* the following providers of health care services or supplies from participating in the program under this chapter:

(1) * * *

* * * * * * *

[(5) Any provider—

[(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence professional performance, or financial integrity; or

[(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.]

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).

(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

(1) Any provider—

(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in sub-

section (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

⟦(c)⟧ *(d)* Whenever the Office determines—

⟦(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

⟦(A) has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

⟦(B) has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies;⟧

(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed,

(B) charges in violation of applicable charge limitations under section 8904(b), or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

* * * * * * *

⟦(d)⟧ *(e)* The Office—

(1) * * *

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【(e)】 *(f)* In making a determination relating to the appropriateness of imposing or the period of any debarment under this section *(where such debarment is not mandatory)*, or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) * * *

* * * * * * *

【(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.】

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

* * * * * * *

(3) Any notice *of debarment* referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of time for which such debarment is to remain effective. *In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).*

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period, if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under 【subsection (b) or (c)】 *subsection (b), (c), or (d)* for continuing the debarment; and

* * * * * * *

【(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.】

⟦(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the provider in any such hearing.

⟦(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.⟧

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

⟦(h)⟧ *(i)* A civil action to recover civil monetary penalties or assessments under subsection ⟦(c)⟧ *(d)* shall be brought by the Attorney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund. *The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.*

⟦(i)⟧ *(j)* The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, *which may be underwritten by participating affiliates licensed in any number of States,* offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

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§ 8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

§ 8909. Employees Health Benefits Fund

(a) * * *

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(e)*(1)* Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

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